

The
Robert Wood Johnson
Foundation
Annual Report 1980

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January 1, 1980 through December 31, 1980

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Introduction



The Robert Wood Johnson Foundation is an independent philanthropy interested in improving health care in the United States. It was established in 1936 by General Robert Wood Johnson, who died in 1968.

Robert Wood Johnson devoted his life to public service and to building a family-owned business into a major international corporation. An astute businessman, a statesman, soldier, and patriot, General Johnson devoted much of his life to improving the world around him. He had a tenacity of spirit that enabled him to accomplish many of his goals,

but he also planned for the long-range fulfillment of other objectives that could not be achieved in one man's lifetime.

Despite the intensity and determination he displayed in his role as a business leader, General Johnson had a warmth and compassion for those less privileged than he. He was always keenly aware of the need to help others, and during his lifetime, he helped many quietly and without fanfare.

The true measure of General Johnson's deep concern for the needs of others was his decision to leave virtually his entire estate to The Robert Wood Johnson Foundation. With the settlement of this bequest in December, 1971, the Foundation began its transition from a local institution active primarily in New Brunswick, New Jersey, to a national philanthropy.

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The
president's
statement

The 1980's: adapting the Foundation's program to changing problems

During the last 18 months, The Robert Wood Johnson Foundation has comprehensively reviewed its grant-making goals. We have examined our program in relation to: the current status of American health and medical care, what has happened since we began our work in 1972, various economic and other projections about the 1980's, and how the decade ahead may influence the kind of personal health care available to people in this country.

To help us decide where our funds might be put to work most effectively in the 1980's, we have obtained advice and counsel from many people within and without the health professions. We have reviewed numerous studies exploring the economic, social, and political circumstances projected for the 1980's, and have tried to weigh their implications for the health field.

My message this year summarizes what we have learned from that review and presents adaptations within our grant program that we hope will be responsive to the most visible health care needs of the times.

Changing health care scene—the bright side

The current health and medical care scene is significantly better than what we encountered nine years ago. In 1972 many people were discouraged and pessimistic about our national ability to bring more and better medical care to many Americans—"health care crisis" was much in the discussions of the day. Despite large government expenditures during the 1960's, front-line ambulatory medical care remained hard to come by, and dwindling numbers of health professionals were rendering general medical care services. Institutions—hospitals, academic medical centers, and public health facilities—also appeared unresponsive to people's general medical care needs, and stories about the unavailability of care were much in the public eye.

In 1972, we decided to target our grants on this area and began supporting those working on ways to improve the provision of general medical care services. We also decided to encourage studies on how to improve the quality of that care. Lastly, we decided to support a few groups working to develop information needed by those formulating and evaluating health policy.

Since 1972, we have made grants totalling \$407.4 million. More than \$313 million has gone to groups and institutions working

to improve access to ambulatory medical services. Another \$52 million has supported studies and other activities related to the quality of medical services rendered, and slightly over \$24 million has gone to groups working to make better information available to public policymakers.

Although some Americans still have serious problems in finding a doctor (which I will discuss later), overall access to physicians' services has remarkably improved. Further, physician care is now more readily available to those most in need. Poor people and black people—both groups which have heavy burdens of illness—are now seeing physicians as often as those who are not black and those with adequate incomes. Poor children and poor elderly people are also getting a greater share of physician services. Seventy-eight percent of Americans state that they have a personal physician they can identify by name, and only two percent indicate that they cannot obtain any sort of medical care on a regular basis. Projections from these and other data, developed with Foundation support over the past few years, suggest that by the mid-1980's, 85 percent of Americans can have a personal physician, which we believe is probably about the maximum number who will avail themselves of such an opportunity.

The increasing availability of one-to-one, personal physician care is also reflected in hospital outpatient departments—the place many people turn for care when they have no personal physician. Between 1970 and 1975, hospital outpatient visits were rising at the alarming rate of 14 percent per year. However, since 1976, the number of outpatient visits has plateaued. Visits to hospital emergency rooms—also a frequently used source of care for doctorless people—have fallen from annual increases of 13 percent to less than 4 percent.

Much of the improvement in numbers of people with a personal doctor comes from the large increase during the last eight years in the numbers of men and women training to become physicians. The number of medical students has increased by over 50 percent, and residency opportunities for those interested in generalist careers have been rapidly expanded. Numbers of nurses, nurse practitioners, physician's assistants and dentists have also increased—all contributing to making health care, generally, more available.

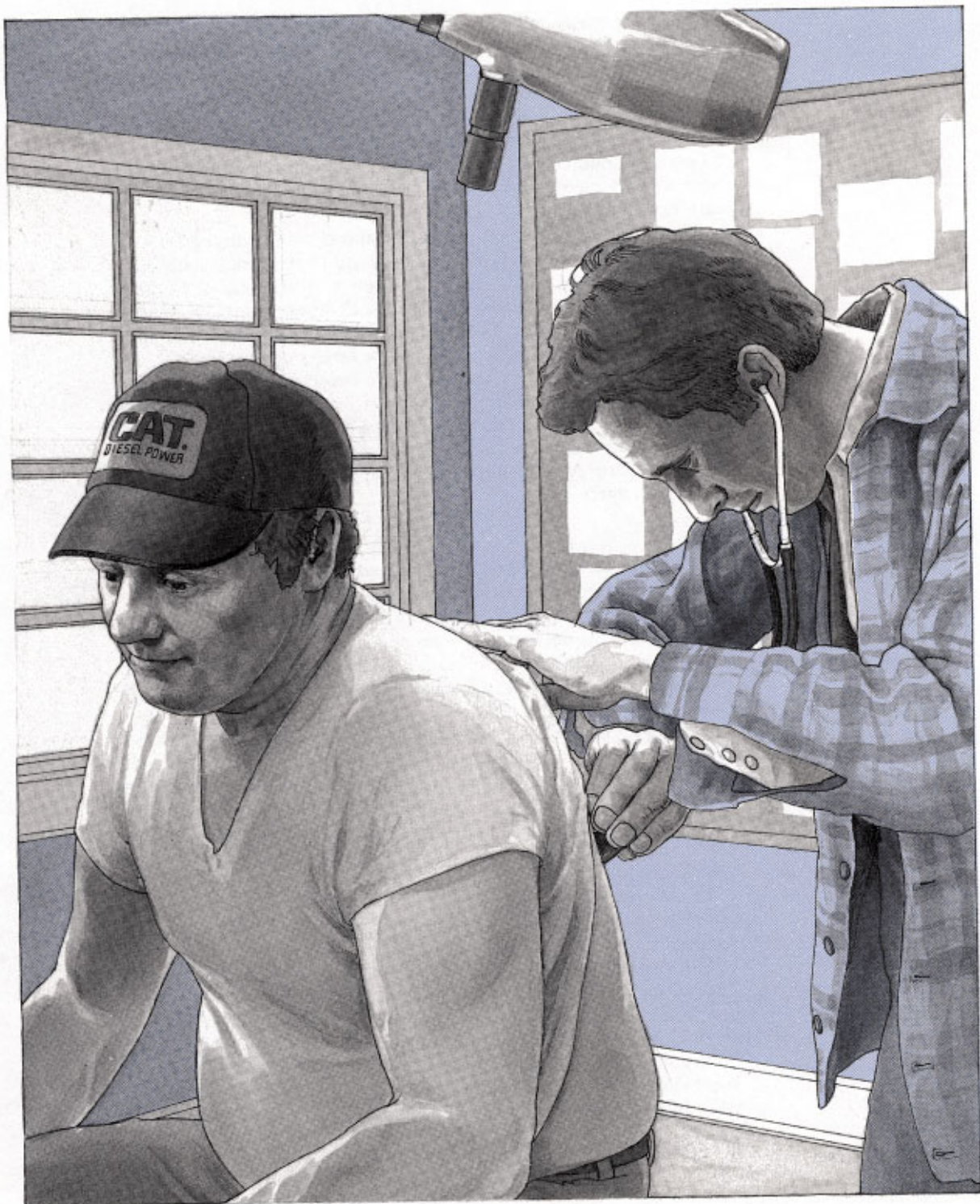
During this same eight years, overall death rates for residents of the United States have been falling more sharply than at any previous time in this century. Eleven of the 15 major causes of death, including our major killer—coronary heart disease—have been coming down, and infant and maternal mortality rates have shown a steep decline.

Although the two cannot be causally related, these improvements have occurred in parallel with more readily available medical care. Problems remain, but as a nation, we have made progress.

A new decade—a new challenge

The advances of the 1970's have been the good news, but our review of the available evidence and discussions with national leaders suggest a potentially less favorable decade ahead. Political, economic and social trends may impede further improvements in all aspects of health and medical care: biomedical and health services research, health professional training and health and medical services. All are seen competing for increasingly limited funds. Hospital administrators, medical school deans, practicing physicians, government officials, economic forecasters, and national leaders all see a series of major national problems producing forces dampening expenditures for health care in the 1980's. Let me summarize them:

1. An indeterminate period of slow economic growth, perhaps the slowest since World War II. This is already forcing the health care sector to flatten or reduce current and planned expenditures.
2. Continuing or increasing inflation. This has been a major problem in the health care field, and continuing rises in health costs beyond what is happening in the rest of the economy are likely to lead to increased governmental intervention.
3. The possibility of decreased, real personal income. This would leave consumers with less purchasing power for new health care services.
4. A dampening in real growth of federal expenditures, with rates of increase falling to about one quarter of that in the decade we have just completed. The effects would be important in the health sector, which now claims 13 cents out of every non-defense federal budget dollar.
5. A similar fall-off to virtually no-growth in state expenditures. Like the federal dollar, these funds have been of increasing importance to both public and private hospitals and medical schools.
6. A decline in private philanthropy's share of support for health activities. This is projected to fall from about 4.5 percent of the total spent in health nationally in 1970 to 1 percent by 1990.
7. Lastly, and perhaps most troublesome, is a plateauing or continuing decline in America's productivity. Remedying this is seen as so important to the national economic situation that it will involve all parts of the economy, including health care—the nation's second largest service industry.



The widespread publicity about these conditions has been understandably accompanied by significant changes in America's attitudes. Most recent polls show a shift from optimism to pessimism when Americans are asked if they expect any improvement in the quality of their lives. In 1979, over 62 percent of American families anticipated an era of enduring shortages. Of particular interest to us, 53 percent doubted they could pay for a major illness, and 38 percent were already having difficulty in meeting routine health care expenses.

These perceptions of tougher times ahead have changed the way Americans rank national issues. In the early 1970's, public concern about social issues like better health, better distribution of medical services, and better education pushed such issues to high visibility on the national agenda. Those views clearly led to public and private programs which have brought about the improvements in the availability of care I have described. However, attitudes today have shifted, and people are almost exclusively concerned about economic issues. Perhaps in part because finding a doctor is no longer such a worry, the public now lists high costs as the single most important problem facing American medicine, and when polled independently, physicians agree.

Implications for philanthropic institutions

The improvements in access to care, the changes in economic outlook, the shifts in public concerns about what needs attention, and the probable decline in federal and state funds available for new developments have significant implications for all who work in the field of health care. They also have some particular implications for foundations working in this sector.

During the past eight years of economic growth and expansion in the medical care sector, many of our most important Robert Wood Johnson Foundation programs moved swiftly into national policy and financing. This was true of programs in emergency medical services, rural health care, primary care residencies, community hospital group practices, school health, child abuse, and regionalization of obstetrical care.

In the early part of this new decade, it seems unlikely that foundation-assisted demonstration programs will be adopted or adapted by others as swiftly.

It also seems clear that it will be much more difficult for groups or institutions to initiate new or experimental efforts: (1) to improve access to medical care for those who still have problems, or (2) to try new ways to deal with shortfalls which continue to exist. Both public and philanthropic monies to support new programs will be in short supply. Academic health centers, for example, project little or no growth in monies available for medical education or biomedical

research, and some of these institutions indicate that their overall financial future looks precarious.

Moreover, more constrained economic times may well lead to a retreat from some of the gains made during the last decade. Lack of outside support and rising tuitions will tend to decrease the entry of minorities into the health professions. We also are likely to see some of the groups that have now entered the mainstream of American medical care—particularly poor and minority people—to be once again disenfranchised. Indeed our surveys indicate that there has already been a significant decrease in poor people covered by public reimbursement programs.

The Foundation's program for the early 1980's

With the facts and projections I have recounted as backdrop, the trustees of the Foundation have agreed to adapt our grant program to try to keep a sharp focus on the emerging problems in health





and medical care and to be as helpful as possible to those working to solve them.

We remain committed to making personal health care more equitably and widely available. But for the early 1980's, we have agreed to place major support behind programs which can encourage health institutions to find new ways of increasing their own effectiveness without sacrificing quality. We believe such a focus can help the nation's large health service sector to play an appropriate role in improving the overall economic outlook of the United States. Further, we believe such a focus can allow those working in health care to take a logical next step which has long seemed important to many, and which will be our third program interest—namely to devote more attention to helping people maintain or regain the highest possible level of personal function in their everyday lives.

Let me expand on each of the objectives we have set for ourselves for the years just ahead:

1. Programs to improve access to personal health care for the most underserved population groups.

Here we will continue to support the kinds of programs we have encouraged since 1972, but in a much more targeted manner on the estimated 12 to 15 million Americans who continue to face a series of non-health-related barriers to the medical care they need.

First, a number of them live in geographic isolation in the rural countryside or in seriously blighted inner-city areas. Absence of, or long distances between, health facilities or health professionals; poor public transportation; or lack of basic public services—all make it especially difficult for such groups to gain access to care.

For some, these problems are often compounded by cultural isolation. They do not speak English or they do not feel comfortable in traditional mainstream American medicine—certain groups of American Indians, or Mexican immigrants or other Hispanic-heritage people are having serious problems getting medical care.

Others among these 12 to 15 million people remain outside the mainstream of medical care because they either move around frequently or live in homes for the aged, mental hospitals, or other such institutions.

Finally, many of the poor or near-poor are not covered by public reimbursement programs or private insurance and are simply unable to afford the medical care they need.

More doctors, or even more dollars to pay for care, will not solve the access problems which plague these groups. We have begun to use the term *structurally underserved* to characterize their plight, for in many ways they resemble the structurally unemployed—people who are unable to find work, even in a strong job market,

unless they receive job training or other special help. In our judgment, the structurally underserved, too, need assistance.

To resolve the problems for these Americans will be very difficult, and for some, impossible. Where it is possible, medical service programs will have to reach out, as distinct from the usual pattern of patients seeking their own care. Recognizing these difficulties, we will encourage groups and institutions making previously untried efforts to deal with these residual access problems.

We will, of necessity, have to be quite selective—our resources are such that we cannot pay for services *per se*. Moreover, we will look most favorably on programs that appear to have reasonable prospects for eventually becoming self-sustaining.

2. Programs to make health care arrangements more effective and care more affordable.

Despite the rapid growth in health care—from the employment of 1.6 million people in 1946 to almost 7 million in 1980—little attention has been directed at improving the output of this massive system, and many believe that the ballooning health sector is a significant factor in slowing down the economy as a whole.

Under this objective, we will support a variety of research, development and demonstration projects aimed at increasing the capability and efficiency of health services that can bring about tangible improvements in the health status of people and slow the rate of increase in the costs of personal health services. We hope our focus on the effectiveness of the delivery system will encourage a whole series of imaginative experiments.

3. Programs to help people maintain or regain maximum attainable function in their everyday lives.

Medical efforts to improve day-to-day individual functioning can have a direct and powerful impact on the individual, the family, and even the nation at large.

The important effect of illness and disability on the national economy is generally unrecognized. For example, during the same years that U.S. productivity sharply declined, the number of men 45 to 65 years of age unable to work at their usual jobs due to debilitating effects of long-term illness more than doubled. In 1979, illness caused the loss of 465 million work days—12 times more than the number of work days lost due to strikes.

While many non-medical factors—sick days, disability benefits and the like—complicate the picture, just a 10 percent decrease in work lost to disability and illness would markedly improve the nation's economy and productivity.

Changes in the makeup of the work force also underscore the need to focus on projects to help individuals maintain their functional ability. Moving the compulsory retirement age back will add an

estimated 1.4 million more workers to the labor force, a significant number of whom will have some type of long-term disability or chronic disease which can affect on-the-job performance.

The need for increased attention on people's functional ability also stems from health care problems that are dramatically different from the infectious disease pattern that prevailed before World War II. Eighty percent of health care resources in the United States are now devoted to chronic disease. Over 60 percent of patient days of hospitalization in acute hospitals are due to chronic disease problems, and over 50 percent of the visits to physicians are accounted for by chronic conditions.

But it is not simply the problem of chronic disease that we wish to address here. It is our hope that more attention to factors and attitudes and approaches which return people swiftly to independent existence, following an acute illness or with a chronic condition, and even in the face of some impairment, may help American medicine to move beyond what many regard as its preoccupation with the prevention of death.

What has been called the third phase in medicine—a renewed focus on the restoration of an individual to full functioning—can have great appeal to many concerned with health precisely because of the impressive improvements in access to medical care and the





extraordinary gains in American health statistics. Both within medicine and without, there has been a significant upsurge of interest in how medical or health care can better preserve productive functioning. Providers and patients alike have become increasingly interested in whether people's lives will be truly improved by increasingly complex and expensive medical technologies. Thus it seems appropriate to concentrate more aggressively on those kinds of medical and health-related programs which are targeted at rapidly restoring individuals to adequate personal functioning in everyday life.

The Foundation's role

There are many groups and institutions already hard at work on various facets of the problems that fall within our program objectives, and funds many hundred-fold those of this foundation are already being devoted to coping with them. Consequently, much of our recent attention has been devoted to the question: within the limits defined by our resources and objectives, what *role* can a foundation play in supplying otherwise missing ingredients to encourage progress in the areas I have outlined?

It is readily evident that we cannot, with our relatively limited resources, underwrite the costs of health or medical care services. However, in the past, increases in the effectiveness and efficiency in various sectors of American enterprise have closely followed significant investments in research and development in a climate receptive to innovation. Yet in recent years—despite enormous pressures for improvements in the health sector—monies available for health care R&D have been rapidly dwindling, and are likely to be in even shorter supply during the early 1980's.

It seems unlikely that responsiveness and effectiveness in the health sector can be readily increased unless there are more opportunities to develop and test patient care alternatives. These should hold the promise of being less expensive, equally effective, and capable of restoring people more rapidly to maximum function. Most importantly, the practical worth of such innovations should be tested before they are broadly implemented. We believe our role is to support such efforts. We can help direct greater attention to what we have come to call "R&D on personal health and medical care practice."

Within the limits of our resources and within the three objectives I have described, we intend to provide funds for the following kinds of activities:

1. The development and testing of new and previously untried approaches to health care problems.

As a nation, we have already applied much of what is known to the problems we have described. To advance, we need to replenish the

reservoir of practical approaches. We will support some of the approaches that appear most promising which have not been previously explored.

2. Demonstrations to objectively assess the operational effectiveness and value of selected new health care arrangements and approaches which have been shown to be effective in more limited settings.

In a period of economic constraint we believe that increased expenditures for patient care should be made on the basis of reasonable evidence that investment in a particular approach or program will actually improve the lives of people. This becomes particularly important during a period when so many social needs will be competing for diminished funds. Here we will try to support some projects where those involved appear prepared to, and capable of, conducting a study which has prospects of obtaining reasonable answers to some deceptively simple questions: Does it improve health and function? Does it restrain costs? Does it offer a better way to deliver care than existing alternatives?

3. Projects designed to promote the broader diffusion of programs that have been objectively shown to improve health status or make health care more affordable.

Knowledge about the most effective ways of managing health care problems is sometimes slow to be disseminated. In certain instances, the Foundation will support efforts to help new methodologies and arrangements for health care to be more swiftly incorporated into the mainstream of medical practice. Such support will be limited to innovations within our program objectives that have been fully tested, evaluated, and shown to be worthwhile. The goal in such instances will be to improve professional or organizational capacities and receptivity for applying new knowledge.

At the same time we are broadening our grants program agenda, we are setting in place much more rigorous criteria for prioritizing the proposals we receive. I have outlined those criteria here so that all who seek our help can have as clear a view of our guidelines as I can articulate. However, even after proposals have met all these tests, we still will have to make hard choices. Experience has shown that we do not have sufficient funds to meet all the in-program, on-target proposals we receive.

Obviously it will take time for us to move into these new areas. Further, because we remain committed to a number of programs supported during the 1970's, there will be a gradual phasing-in of new programs, and continuing work in some sectors where we have worked in the past. Our new objectives provide a logical continuity with the issues which have received our major attention since 1972.

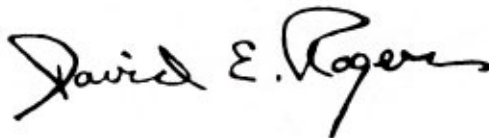
Our hopes for the future

Put quite simply, the more difficult economic situation is impeding progress in the areas of health care in which we operate, and threatens many of the more important health gains of the 1970's. Thus our funds will be an even more important source of "venture capital" than in times past, and we believe that careful targeting and careful evaluation of the effectiveness of programs we support is even more critical than before.

We hope our changes in emphasis will continue to encourage those working on the most pressing problems in health and medical care, particularly those that relate to the most acute concerns of the American people: the rapidly increasing costs of everything and the apparent decline in the effectiveness of many of our ways of doing things.

We also hope that our program focus will enable the Foundation to continue to support the people and innovations needed to make effective health care available to all.

Over the past nine years we have been impressed with the creativity of many groups and individuals working in the field of health and medical care. We are suggesting that this creativity now needs to be directed toward how to make systems of medical care more efficient and the care dispensed more effective, so that we can retain the advances of the last decade in a period of economic constraint. We are confident that this can be done, and we look forward to working with those who will be at the forefront of these new areas.

A handwritten signature in black ink that reads "David E. Rogers". The signature is written in a cursive style with a large, sweeping "D" and "R".

The 1980
grant program

The 1980 grant program

During 1980 the Foundation made 128 grants totaling \$46.4 million in support of programs and projects attempting to improve the American health care system by making quality health care more readily available. Three principal types of activity were supported:

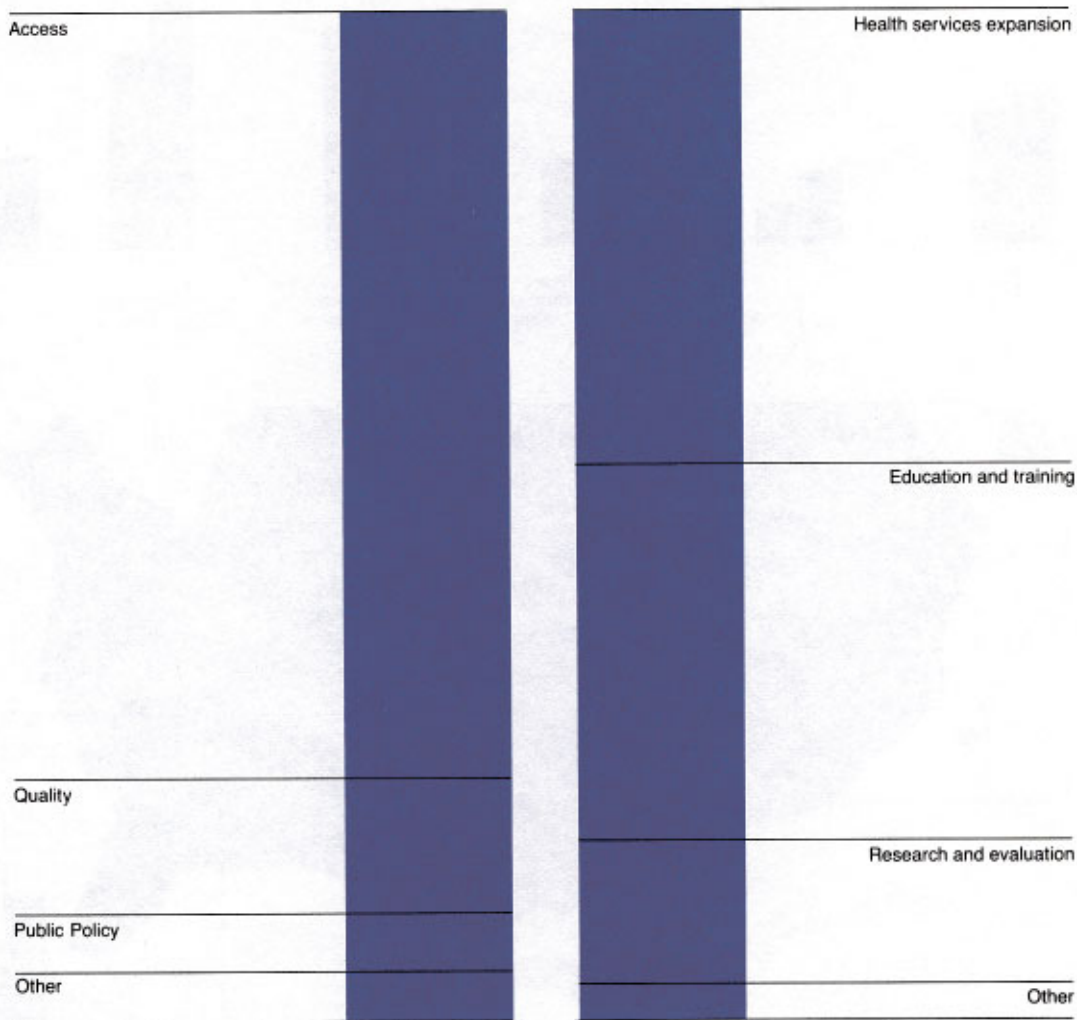
- developing and testing new ways of providing general medical care services, \$31 million, or 67 percent;
- helping health professionals acquire new skills to better deal with ambulatory care problems, \$8.7 million, or 19 percent;
- increasing national awareness and understanding of the problems involved in planning and putting into place more effective health care systems, \$5.1 million, or 11 percent.
- other projects supported by the Foundation received \$1.6 million, or 3 percent.

Viewed another way, within our principal fields of interest, the 1980 grant funds were distributed as follows:

- \$35.7 million, or 77 percent, for programs to increase people's access to primary care services;
- \$5.9 million, or 13 percent, for programs to improve the performance of the health care system;
- \$2.0 million, or 4 percent, for programs and information useful to those formulating public policy in health; and
- \$2.8 million, or 6 percent, for a variety of purposes in the New Brunswick, New Jersey area where the Foundation originated.

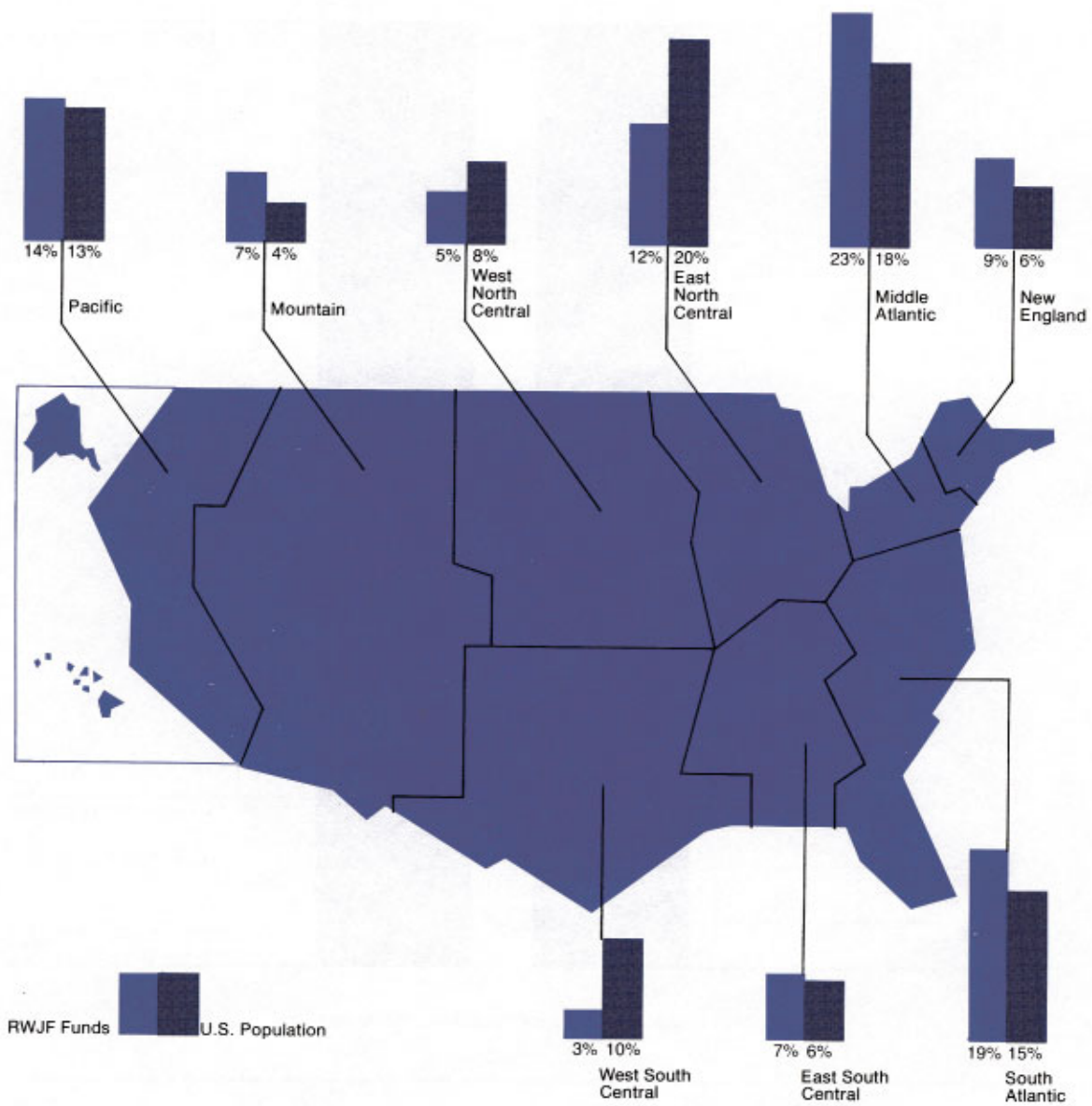
Since becoming a national philanthropy in 1972, we have appropriated \$407 million. The distribution of these funds by types of activities supported and by our principal fields of interest is depicted in the chart on page 25. The geographic distribution of these funds is depicted in the chart on page 26.

**Appropriations by
RWJF Objectives and
Types of Activities
Funded, 1972-1980**



RWJF 9-year appropriations: \$407 million

**1972-1980 Appropriations
by Geographical Regions
Compared to Population**



Major developments in the 1980 grant program

Information derived from national studies on access to care, described earlier in this Report, suggest that general medical care services are becoming more accessible to more Americans. As a result, programs receiving support in 1980 were principally directed toward those groups which continue to experience the most difficulty in getting appropriate care—residents of inner-city and rural areas, low-income elderly, and children and adolescents.

National program grants

During 1980 grants were made under five invitational programs directed toward improving services for these groups. These programs were first announced in 1979, advisory committees formed, and applications invited and reviewed. No further grants are planned under these one-time, national programs, though we remain interested in these fields.

- Eight states received grants to help elderly people with health problems gain access to the medical and social services they need to maintain reasonably independent living arrangements. The grants support the establishment of a local community coordinating unit in a designated site in each state to work with existing private voluntary and public agencies to identify health-impaired elderly persons needing assistance and to tailor individualized packages of services to meet their needs. (See page 54 for a list of grantees under the Health-Impaired Elderly program.)

- In an effort to bring care to isolated rural areas where infants die at rates much

higher than the national average, 10 medical schools received grants under our Rural Infant Care Program. The health departments in these states have received U.S. Public Health Service grants to underwrite the costs of improved services to mothers and infants in counties with high mortality rates. Under the Foundation program, skilled obstetricians, pediatricians, and other health professionals from the medical schools will help the health departments plan and organize special programs, assisting smaller community hospitals and local physicians, community clinics, and health department nursing stations. (See page 58 for a list of grantees.)

- Under the Teaching Hospital General Medicine Group Practice Program, adult patients who use the outpatient clinics and emergency rooms of 15 medical school-affiliated hospitals as their principal source of general medical care will have an office-based physician group practice to meet their on-going medical care needs. Teaching hospitals now care for 25 percent of those who use hospital-based ambulatory care services. However, when these services were developed, they were not envisioned as principal providers for large numbers of people, nor were their staffs recruited or organized to serve this role. The practices being developed by these hospitals' departments of medicine are expected to improve care, to become centers for expanded residency training, and to provide a more realistic and appealing setting in which to teach and learn office-based ambulatory care. (See page 59 for a list of grantees.)

- As a step toward the revitalization of medical care services in the nation's central city areas, four additional urban-based medical schools and hospitals received grants in 1980 to develop networks of health

centers serving medically underserved inner-city neighborhoods. The grants are contingent upon these institutions receiving federal Urban Health Initiative grants to help cover the costs of medical services being provided in these centers. (See page 60 for a list of 1980 grantees, and page 76 for a list of earlier grantees.)

The Foundation also supports external studies of its national programs to determine how well these programs meet their goals. In 1980, grants were made to plan or conduct studies of the rural infant care, health-impaired elderly and teaching hospital programs begun this year, and three national programs begun in 1979.

Care of the chronically ill

The fifth national program under which grants were made in 1980 addresses the special needs of the chronically ill. Such life-long illnesses—for example, heart disease, arthritis, chronic obstructive lung disorders, diabetes, and stroke—together affect an estimated 100 million Americans, account for half the nation's physician visits, and 40 percent of days people spend in hospitals.

Physicians can control or arrest many chronic illnesses within an office setting. However, in sharp contrast to hospital practice where physicians can count on round-the-clock coverage by nurses, house staff and others, physicians rarely have comparable services available to help manage the treatment of chronically ill, ambulatory patients and to ensure patient compliance with diet and medication regimens.

Under the Chronic Disease Care Program, we are assisting eight physician-directed, nurse-managed, patient-care support systems that will meet this need. Four grants were made to hospitals under this program in 1979 (see page 65). Four final grants were made in 1980 (see page 52).

A North Carolina program that takes

a different but complementary approach to the care of the chronically ill received a planning grant as a single-site project.

There, chronically ill patients who use the general medical clinics of six participating community hospitals for their routine care, will be served by teams of specially trained nurses backed up by hospital-based physicians. The nurses will utilize physician-developed protocols and regimens to manage and monitor patient progress.

Care of the elderly

In addition to our national program to enhance community-based health care programs for the elderly, we continued a project at The Johns Hopkins Hospital to place discharged elderly patients in the homes of "foster families" that have been specially selected and trained. The purposes of the project are to assess the costs and functional-status outcomes of foster-family care, in contrast to hospital or nursing home care, and to define criteria for providing foster care at a satisfactory standard.

Another project to help local communities strengthen services available to the elderly involves nearly 1,000 college students working under the auspices of the National Council on Aging, Washington, D.C. With our continued support, students at seven colleges are assisting with hospital discharge and follow-up projects, helping older people understand and use local health care screening, referral and other services.

Care of children and adolescents

The majority of American children are quite healthy, troubled only by the usual minor, self-limiting illnesses of childhood. For others, circumstances are quite different, especially for those children with disabling and developmental problems which manifest themselves early and remain life-long problems.

Two university medical schools received

grants in 1980 to develop large-scale programs to improve the care available to such children. In Iowa, the target population is the 1,700 newborn whose low birthweight or other complication makes it necessary for them to begin life in one of the state's 11 neonatal intensive care units. Because they appear to be at substantially higher than average risk of developing serious medical problems later, those children with

difficulties will be closely followed by University specialists over the first five years of life. Where problems are detected, special treatment plans will be devised and carried out in the children's home communities.

In Florida, the target is approximately 1,000 children with epilepsy, rheumatic heart disease, serious vision and hearing problems, blood diseases, orthopedic problems and other severe chronic conditions.



For large numbers of these children living in a predominantly rural, 16-county area of the state, the University of Florida's teaching hospital at Gainesville is a principal source of care. Under this program, 20 nurses from these rural communities will receive special training to assist University-based pediatric specialists to provide routine management of chronic illness locally. The nurses will also work with school teachers to see that classroom and recreational activities become as "normal" as possible, and will assist the families to find, pay for, and coordinate medical and rehabilitative services. If the program proves effective, the State's Division of Children's Medical Services hopes to extend it to other areas of the State.

Other grants were made to the Boston City Hospital to examine health factors affecting chronic school absenteeism and the impact of medical services on school attendance and performance, and to Columbia University to complete a study of health care utilization in adolescence and subsequent health behavior in adulthood.

Primary care group practices

Two fundamental problems face those seeking to develop and sustain new ambulatory service programs in underserved areas: the absence of physicians and other skilled providers, and insufficient income for a medical practice to achieve financial viability. In 1980 we supported projects taking a fresh approach to both problems.

The University of Iowa College of Medicine found that despite a growth in its family physician training program from seven residents in 1971-72 to 166 in 1979-80, simply training additional physicians had not, alone, improved access to general medical care services, especially in sparsely populated areas of the state.

In an effort to improve the situation, the University organized a planning and

management team to work with community leaders in a number of the state's 100 small rural hospitals to develop new group medical practices attractive to young physicians and their families. The University team guides the local community in raising funds to renovate and equip each practice site and, once a physician team has been recruited, provides on-going clinical and management assistance. These sites will also be part of the University's expanding residency training program. A federal grant will provide operating funds while these new practices seek to achieve fiscal viability.

The financial underpinnings of ambulatory care programs is the focus of a project by the Associated Clinics of Appalachia. This clinic consortium, organized following the abrupt end of a prepayment system developed 25 years earlier by the coal industry and miners' union to partially subsidize the operation of health clinics serving miners, has launched an effort to synthesize financial and organizational data on the common problems these clinics face. The Association will use this and other information to work with other providers, and government, industry, and union groups in the region to stabilize these clinics and experiment with alternative reimbursement mechanisms.

Responding to the large numbers of people who depend on their local hospitals as a regular source of medical care, many community hospitals are sponsoring the establishment of primary care group practices. Developing such hospital-sponsored practices involves complex organizational, manpower, management and fiscal issues. A 1980 grant is helping the American Hospital Association to offer practical financial and management assistance to community hospitals through its new Center for Ambulatory Care services.

Also, the University of Utah received continued support of its program to assist 37 rural health centers in that State.

New skills for health professionals

As the complexity of health care increases, more physicians and other health professionals who combine clinical skills with the analytic capability of examining broad health care problems are needed. One promising approach to meeting this need was initiated by five medical schools in 1969.

Beginning in 1973, this effort was continued and expanded as the Robert Wood Johnson Clinical Scholars Program. 1980 grants will continue this program until 1983, enabling 20 young physicians annually to undertake two years of graduate-level study and research in a number of non-biological disciplines which bear on medicine and health affairs, including economics, epidemiology, law, management, and the behavioral sciences. Former Clinical Scholars are developing and managing a variety of health care institutions and

delivery systems, and several are contributing to the formulation, conduct and evaluation of public policy issues in the health field.

Efforts to increase the enrollment of minority students in medical schools have received support from the Foundation's earliest days. In 1980 two such projects received continued support: the special summer tutorial programs a number of medical schools sponsor for minority premedical students, which is administered by the National Fund for Medical Education; the National Medical Fellowships' Scholarship Program for minority medical students also received continuing support in 1980. In addition the concluding grant was made under the Foundation's Guaranteed Student Loan Program for medical, dental and osteopathic students, administered by United Student Aid Funds.



Understanding of health issues

Our 1980 grants include support for a limited number of research studies that fall within the Foundation's fields of interests and can contribute useful information in planning future public and private initiatives.

For example, it is hoped that a project by the National Bureau of Economic Research to develop specific measures of the effectiveness of the health care system may serve as a guide to the design and evaluation of future programs in this area; a University of Maryland study is looking at the nature, extent and causes of the nurse shortage that hospitals in many parts of the country are experiencing; and a Brandeis University group is looking at the financial viability of free-standing community-sponsored medical service programs in comparison to those affiliated with medical schools.

Although hospice care, a new type of specialized assistance to terminally ill patients and their families, has grown rapidly in the U.S. in recent years, there is little or no objective information on the effects of these programs on patients and families to guide policymakers in making future decisions regarding hospice-type

services. A one-time, nationwide study supported jointly by the Foundation—with a 1980 grant—and the U.S. Department of Health and Human Services, and the John A. Hartford Foundation will compare the outcomes of hospice care with traditional modes of care for the terminally ill.

Other grants build upon previous Foundation programs. The University of Chicago will examine the location and types of practice chosen by recent graduates of Foundation and federal government-sponsored primary care physician training programs in internal medicine. A University of Washington-Seattle study will develop practice profiles of family and general practitioners.

New Brunswick Grants

In addition to its continuing support of hospitals and other health-related agencies in the New Brunswick, New Jersey area where the Foundation had its origins, in 1980 the Foundation also made a grant in continued support of the New Brunswick Development Corporation's technical assistance role in the major revitalization program that has been launched by New Brunswick Tomorrow.

Program information

A list of all grants made in 1980 begins on page 51, followed by a list of grants made in previous years, which were still active in 1980 (i.e., those with unpaid balances on January 1, 1980).

A Descriptive Program Summary for most of the grants listed in this Report is available free upon request. Requests should include the title of the grant, the institutional recipient, the grant ID number, and should be addressed to:

Communications Office
The Robert Wood Johnson
Foundation
Post Office Box 2316
Princeton, New Jersey 08540.

Also available without charge from the same address are copies of Special Report, a non-periodic publication, which describe the progress and outcomes of some of the programs we have assisted.

The Special Reports are:

- Dental Care for Handicapped Americans
- School Health Services
- Regionalized Perinatal Services
- A New Survey on Access to Medical Care
- Emergency Medical Services
- New Roles for Nurses in Family Care; Citizen-Legislators: Coping with the Health Agenda; Unraveling the Battered Child Syndrome.

In addition, a series of videotape cassettes ($\frac{3}{4}$ inch) which describe the problems we are addressing and some of the activities we have supported are available without charge from the same address.

The videotapes are:

- Caring for People: Nursing Faculty in Primary Care (14 minutes)
- Every Ten Seconds (52 minutes on child birth) © Boston Broadcasters, Inc.
- House Call: Cambridge Health Care (23 minutes on school health services) © Boston Broadcasters, Inc.
- House Call: What Happens to Chris? (23 minutes on learning disabilities) © Boston Broadcasters, Inc.

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Each year the Foundation's grantees report the publications and other information materials that have been produced as a direct or indirect result of their grants.

In 1980 these reports cited 43 books, 121 book chapters, 575 journal articles, 273 reports, and 35 films, tapes and other audiovisual products.

This bibliography is a sample of citations from each category reported in 1980, and from among the publications of the Foundation's staff. These publications are available through medical libraries and/or the publishers. Copies are not available from the Foundation.

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An Interview with Sherry Paukert—A Mother's Perception of Her High-Risk Infant. (20 minute videotape) by Feizal Waffarn. Los Angeles: University of Southern California School of Medicine, 1978.

Caring for People: Nursing Faculty in Primary Care. (14 minute videotape) by William E. Walch. Princeton, New Jersey: The Robert Wood Johnson Foundation, 1980.

Look At Me. (16 mm school health education film) by Lawrence Hall of Science. San Francisco: Monaco Labs, 1976.

Pediatric Emergency Management. (A series of six videotapes.) Edited by Stephen Ludwig. Minneapolis, Minnesota: McGraw-Hill, 1980.

Accidental Ingestions in Children (20 minutes) by William Schwartz.

Cardiopulmonary Resuscitation (28 minutes) by Stephen Ludwig and Robert Ketrick.

Foreign Bodies (25 minutes) by Steven Honkler.

Head Trauma (22 minutes) by Derek Bruce.

Status Epilepticus (20 minutes) by Andrew Hodson.

Upper Airway Infections (19 minutes) by Gary Fleisher.

Promoting Adherence to Therapeutic Regimens. (32 minute videotape) by Rosemary McClain. Indianapolis, Indiana: Indiana University School of Nursing, 1980.

The Pediatric Examination of Educational Readiness (PEER). (30 minute videotape) by Frank Oberklaid and Melvin D. Levine. Boston: Boston University School of Public Communication, 1979.

The Pediatric Extended Examination at Three (PEET). (40 minute videotape) by James Blockman and Melvin D. Levine. Boston: Boston University School of Public Communication, 1979.

Financial statements

Introduction to statements

The annual financial statements for the Foundation appear on the following pages. A listing of grants authorized during 1980 appears on pages 51 through 61, and a summary of grants authorized in prior years which had not been paid in full as of January 1, 1980 appears on pages 63 through 77. A detailed list of investment securities held at December 31, 1980, although not included herein, is available upon request to the Treasurer, The Robert Wood Johnson Foundation, Post Office Box 2316, Princeton, New Jersey 08540.

Grants authorized in 1980, net of cancellations and refunds of prior years' grants, totaled \$44,015,583. This amount, when added to investment and administrative expenses and excise taxes for the year, exceeded income by \$7,689,960. The comparable figure for 1979 was \$7,717,536, and the total by which grants, expenses and taxes exceeded income for the nine years ended December 31, 1980 was \$191,965,770.

Investment income for 1980 was \$41,429,504, an increase of 13% over the \$36,720,277 earned in 1979. This amount exceeded 5% of the average value of the Foundation corpus for 1980, with the result that for that year the Foundation was on the income standard of payout requirement as opposed to the minimum investment return standard. Expenses in 1980 were \$3,847,706, an increase of 1% over 1979.

William R. Walsh, Jr.
Vice President and Treasurer

Opinion of Independent Certified Public Accountants

To the Trustees of
The Robert Wood Johnson Foundation:

We have examined the statement of assets, liabilities and foundation principal of The Robert Wood Johnson Foundation as of December 31, 1980 and 1979 and the related statement of investment income, expenses, grants and changes in foundation principal for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1980 and 1979 and the investment income, expenses, grants and changes in foundation principal for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Newark, New Jersey,
January 19, 1981.

The Robert Wood Johnson Foundation
Statement of Assets,
Liabilities and Foundation Principal
at December 31, 1980 and 1979

	<u>1980</u>	<u>1979</u>
Assets		
Cash	\$ 210,339	\$ 158,794
Investments (at cost, or market value on dates of gifts) (Note 2):		
Johnson & Johnson common stock— 7,861,086 shares in 1980, 8,011,086 shares in 1979 (quoted market value \$784,143,329 and \$634,878,566)	225,351,054	229,651,059
Other corporate common stocks (quoted market value \$52,231,448 and \$44,233,227)	48,120,835	48,255,987
Fixed income investments (quoted market value \$184,992,796 and \$192,220,795)	228,684,864	223,912,879
Land, building, furniture and equipment at cost, net of depreciation (Note 1)	5,952,733	6,116,237
	<u>\$508,319,825</u>	<u>\$508,094,956</u>
 Liabilities and Foundation Principal		
Liabilities:		
Unpaid grants (Note 1)	\$ 94,284,119	\$ 89,655,806
Federal excise tax payable	819,864	741,344
Total liabilities	95,103,983	90,397,150
Foundation principal	413,215,842	417,697,806
	<u>\$508,319,825</u>	<u>\$508,094,956</u>

See notes to financial statements.

The Robert Wood Johnson Foundation
Statement of Investment Income,
Expenses, Grants and Changes in Foundation Principal
for the years ended December 31, 1980 and 1979

	1980	1979
Investment income:		
Dividends	\$ 19,978,380	\$ 18,528,832
Interest	21,451,124	18,231,445
	<u>41,429,504</u>	<u>36,760,277</u>
Less: Federal excise tax	819,864	726,427
Investment expenses	436,311	438,920
	<u>40,173,329</u>	<u>35,594,930</u>
Expenses:		
Program development and evaluation	2,990,396	2,970,713
General administration	857,310	842,062
	<u>3,847,706</u>	<u>3,812,775</u>
Income available for grants	36,325,623	31,782,155
Grants, net of refunds and cancellations	<u>44,015,583</u>	<u>39,499,691</u>
Excess of expenses and grants over investment income	<u>7,689,960</u>	<u>7,717,536</u>
Additions to foundation principal:		
Net capital gains on sale of securities (Note 3)	2,067,699	13,229,050
Less related federal excise tax	—	14,917
	<u>2,067,699</u>	<u>13,214,133</u>
Contributions received	1,140,297	1,116,529
	<u>3,207,996</u>	<u>14,330,662</u>
Net increase (decrease) in foundation principal	(4,481,964)	6,613,126
Foundation principal, beginning of year	<u>417,697,806</u>	<u>411,084,680</u>
Foundation principal, end of year	<u>\$413,215,842</u>	<u>\$417,697,806</u>

See notes to financial statements.

Notes to Financial Statements

1. Summary of significant accounting policies:

Grants are recorded as payable in the year the grant requests are authorized by the Board of Trustees. At December 31, 1980 unpaid grants are as follows:

<u>Year Grant Authorized</u>	<u>Amount Unpaid at December 31, 1980</u>
1976	\$ 1,785,672
1977	3,459,070
1978	25,154,310
1979	25,378,824
1980	38,506,243
	<u>\$94,284,119</u>

Depreciation of \$217,841 in 1980 and \$200,327 in 1979 is calculated using the straight-line method over the estimated useful lives of the depreciable assets.

Interest and dividend income is recorded when received and expenses are recorded, except for federal excise taxes, when paid. The difference between the cash and accrual basis for such amounts is considered to be immaterial.

2. The quoted market values of investments, particularly in the case of the sizeable holding of Johnson & Johnson common stock, may be greater than the realizable values of such investments.
3. The net capital gains (losses) on sales of securities for the years ended December 31, 1980 and 1979 were as follows:

	<u>1980</u>	<u>1979</u>
Johnson & Johnson common stock	\$6,536,675	\$17,546,645
Other securities, net	(4,468,976)	(4,317,595)
	<u>\$2,067,699</u>	<u>\$13,229,050</u>

4. Substantially all employees of the Foundation are covered by a retirement plan which provides for retirement benefits through the purchase of individually-owned annuities. The Foundation's policy is to fund costs accrued. Pension expense approximated \$179,000 and \$155,300 in 1980 and 1979, respectively.

**Summary of grants
authorized in the year ended December 31, 1980**

	1980 grants authorized
Affiliated Hospitals Center, Inc. Boston, Massachusetts <i>Administration of the Foundation's Teaching Hospital General Medicine Group Practice Program (ID#5332)</i>	\$ 203,322
Alameda Health Consortium Oakland, California <i>Managerial improvement program among its member clinics (ID#5435)</i>	20,000
Allegheny General Hospital Pittsburgh, Pennsylvania <i>Primary care training program for emergency nurses (ID#5426)</i>	89,599
American Academy of Pediatrics Evanston, Illinois <i>Program of regional workshops in school health (ID#5470)</i>	19,125
American College of Physicians Philadelphia, Pennsylvania <i>Conference on health care in nursing homes (ID#5458)</i>	25,000
Associated Clinics of Appalachia, Inc. Bellaire, Ohio <i>Program of technical assistance to member clinics (ID#4951)</i>	335,800
Atlanta University Atlanta, Georgia <i>Workshop program for project directors of the Foundation's preprofessional minority programs (ID#5890)</i>	15,750
Bedford Stuyvesant Family Health Center, Inc. Brooklyn, New York <i>Primary care service program in the inner city (ID#5789)</i>	25,641
Boston City Hospital Boston, Massachusetts <i>Urban health program for adolescents and young families (ID#5446)</i>	931,146

Brandeis University Waltham, Massachusetts <i>Evaluation of the viability of Foundation-sponsored individual service programs (ID#5971)</i>	\$ 358,081
Brown University Providence, Rhode Island <i>Study of the cost and efficacy of hospice care (ID#4785)</i>	550,000
University of California, Los Angeles Los Angeles, California <i>Evaluation of the Foundation's School Health Services Program (ID#4832)</i>	302,690
<i>Evaluation of the Foundation's Hospital-Sponsored Ambulatory Dental Services Program (ID#4756)</i>	676,362
University of California, Los Angeles, School of Medicine Los Angeles, California <i>Evaluation of the Foundation's Teaching Hospital-General Medicine Group Practice Program (ID#5318)</i>	1,113,536
University of Chicago Chicago, Illinois <i>Study of practice profiles of primary care physicians (ID#5970)</i>	499,993
The Foundation's Chronic Disease Care Program <i>Development of physician directed, nurse managed programs providing ambulatory care for patients with chronic diseases (ID#4891)</i>	
Henry Ford Hospital Detroit, Michigan	570,000
Mount Auburn Hospital Cambridge, Massachusetts	558,312
The Staten Island Hospital Staten Island, New York	525,428
Tufts University, School of Medicine Boston, Massachusetts	587,449
The Foundation's Clinical Scholar Program <i>National program to prepare young physicians for new roles in medical care (ID#5109)</i>	
University of California, Los Angeles, School of Medicine Los Angeles, California	946,493

	1980 grants authorized
University of California, San Francisco, School of Medicine and Stanford University, School of Medicine San Francisco, California	\$ 925,288
McGill University, Faculty of Medicine Quebec, Canada	147,331
University of North Carolina, School of Medicine Chapel Hill, North Carolina	893,312
University of Pennsylvania, School of Medicine Philadelphia, Pennsylvania	913,778
Stanford University, School of Medicine Stanford, California	56,342
University of Washington, School of Medicine Seattle, Washington	935,494
Yale University, School of Medicine New Haven, Connecticut	914,981
Administrative Costs Princeton, New Jersey	150,000
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Columbia University, School of Public Health New York, New York <i>Study of utilization of medical services by urban black youths (ID#5420)</i>	62,158
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The Community Hospital Group Edison, New Jersey <i>Equipment support for The Robert Wood Johnson Jr. Rehabilitation Institute (ID#5339)</i>	52,074
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Cornell University Medical College New York, New York <i>Administration of the Foundation's Chronic Disease Care Program (ID#5183)</i>	127,814
<i>Administration of the Foundation's General Pediatrics Academic Development Program (ID#5333)</i>	55,450
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State of Florida, Department of Health and Rehabilitative Services Tallahassee, Florida <i>Improving the functional ability of children with chronic illnesses who live in rural areas (ID#6071)</i>	597,000
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The Foundation Center New York, New York <i>Data collection and analysis on the foundation field (ID#5429)</i>	150,000
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	1980 grants authorized
Georgetown University, School of Medicine Washington, D.C. <i>Analysis of health policy issues (ID#5483)</i>	\$ 188,834
Harvard University, Medical School Boston, Massachusetts <i>Evaluation of the Foundation's Program for the Health-Impaired Elderly (ID#5141)</i>	450,000
Harvard University, School of Public Health Boston, Massachusetts <i>Planning the evaluation of the Foundation's Rural Infant Care Program (ID#5320)</i>	23,918
The Foundation's Program for the Health-Impaired Elderly <i>Coordination and integration of services at the community level for elderly people with health problems (ID#4884)</i>	
Community Care, Inc. Columbia, South Carolina	56,461
First Tennessee-Virginia Development District Johnson City, Tennessee	447,594
The Illinois Department of Aging Springfield, Illinois	581,932
State of Maryland Office on Aging Baltimore, Maryland	592,605
Nebraska Commission on Aging Lincoln, Nebraska	600,000
New York State Office for the Aging Albany, New York	600,000
Ohio Commission on Aging Columbus, Ohio	599,860
Philadelphia Corporation for Aging Philadelphia, Pennsylvania	600,000
South Carolina Commission on Aging Columbia, South Carolina	548,135
The Foundation's Health Policy Fellowships Program <i>One-year fellowships with federal government in Washington, D.C. for faculty from academic health science centers (ID#4888)</i>	
University of California, San Francisco, School of Medicine San Francisco, California	37,800

	1980 grants authorized
University of Colorado, Medical Center Denver, Colorado	\$ 33,865
Michigan State University East Lansing, Michigan	34,800
New England Medical Center Hospital Boston, Massachusetts	35,700
University of Texas Health Science Center at Houston Houston, Texas	35,064
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Hospital Research and Educational Trust Chicago, Illinois <i>Development of a financial and administrative assistance program for hospitals attempting to improve their outpatient departments (ID#5460)</i>	350,000
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University of Illinois, Abraham Lincoln School of Medicine Chicago, Illinois <i>Historical analysis of city hospitals in the United States (ID#6117)</i>	5,700
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University of Iowa, College of Medicine Iowa City, Iowa <i>Iowa Rural Practice Development Program (ID#5745)</i> <i>Follow-up program for newborns treated in intensive care units (ID#5267)</i>	355,927 300,000
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The Johns Hopkins Hospital Baltimore, Maryland <i>Administration of the Foundation's Municipal Health Services Program (ID#5187)</i> <i>Foster family care project for the frail elderly (ID#5716)</i>	104,592 251,046
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The Johns Hopkins University, School of Medicine Baltimore, Maryland <i>Administration of the Foundation's School Health Services Program (ID#5334)</i>	68,215
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Kingston Hospital Kingston, New York <i>Administration of the Foundation's Program for the Health-Impaired Elderly and Perinatal Program (ID#5335)</i>	180,448
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University of Maryland, School of Nursing Baltimore, Maryland <i>Research on factors influencing the hospital nursing shortage (ID#5940)</i>	325,351
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	1980 grants authorized
University of Michigan Ann Arbor, Michigan <i>Development of a data archival system for the Foundation's evaluation studies (ID#5431)</i>	\$ 24,343
Middlesex County College Edison, New Jersey <i>Refresher training to return inactive RN's to nursing service (ID#5340)</i> <i>Health sciences scholarship program (ID#5476)</i>	17,419 15,000
Middlesex General Hospital New Brunswick, New Jersey <i>Purchase of equipment (ID#5423)</i> <i>Planning study on the Hospital's role in ambulatory care (ID#5792)</i>	125,000 110,000
University of Missouri, Columbia, School of Medicine Columbia, Missouri <i>Administration of the Foundation's Rural Infant Care Program (ID#5490)</i>	147,416
Montefiore Hospital and Medical Center Bronx, New York <i>Development of a child care program (ID#5390)</i> <i>Administration of the Foundation's Urban Health Program (ID#5481)</i>	100,000 178,020
National Association of School Nurses New York, New York <i>Training for school nurses in health and development assessments (ID#5095)</i>	150,950
National Bureau of Economic Research Cambridge, Massachusetts <i>Studies of productivity in the health sector (ID#5437)</i>	257,933
National Council on the Aging, Inc. Washington, D.C. <i>Expanded health services for the elderly (ID#5811)</i>	70,000
National Fund for Medical Education Hartford, Connecticut <i>Summer programs for minority premedical students (ID#5826)</i>	100,000

National Medical Fellowships, Inc. New York, New York <i>Scholarship program for minority medical students (ID#5479)</i>	\$ 300,000
New Brunswick Board of Education New Brunswick, New Jersey <i>Program to study school health services (ID#5594)</i>	65,000
New Brunswick Development Corporation New Brunswick, New Jersey <i>Redevelopment program for New Brunswick, New Jersey (ID#6037)</i>	1,500,000
University of New Mexico, School of Medicine Albuquerque, New Mexico <i>Completion of guidelines for curriculum of family nurse practitioner programs (ID#4746)</i>	4,411
University of North Carolina at Chapel Hill Chapel Hill, North Carolina <i>Design of a six-hospital chronic disease management program (ID#5502)</i>	60,328
University of North Carolina, School of Public Health Chapel Hill, North Carolina <i>Research on hypertension among black males (ID#5938)</i>	7,085
Peninsula Hospital District Burlingame, California <i>Development of in-home care systems (ID#5699)</i>	5,000
People-to-People Health Foundation, Inc. Millwood, Virginia <i>Conference on the corporate role in U.S. health care (ID#6124)</i>	25,000
University of Pittsburgh, Graduate School of Public Health Pittsburgh, Pennsylvania <i>Development of a guide for financing, organizing, and staffing pre-hospital emergency medical services (ID#6156)</i>	25,000
Posen-Robbins School District Posen, Illinois <i>Implementation of a school-based health care program (ID#4420)</i>	113,256

	1980 grants authorized
University of Rochester, School of Medicine and Dentistry Rochester, New York <i>Administration of the Foundation's Community Hospital—Medical Staff Group Practice Program (ID#3757)</i>	\$ 278,573
The Rockefeller University New York, New York <i>Planning a teaching and demonstration unit in chronic disease management (ID#4743)</i>	25,000
The Foundation's Rural Infant Care Program <i>Cooperative projects with state health departments to reduce infant mortality and morbidity in isolated rural counties (ID#5540)</i>	
Duke University Medical Center Durham, North Carolina	429,640
Eastern Virginia Medical Authority Norfolk, Virginia	388,304
Louisiana State University, School of Medicine Shreveport, Louisiana	395,389
Medical University of South Carolina, School of Medicine Charleston, South Carolina	349,513
University of New Mexico, School of Medicine Albuquerque, New Mexico	341,161
Ohio State University Research Foundation Columbus, Ohio	328,026
University of Oklahoma, Health Sciences Center Oklahoma City, Oklahoma	356,986
University of Tennessee, College of Medicine Memphis, Tennessee	329,839
Tulane University, School of Medicine New Orleans, Louisiana	395,493
University of Washington, School of Medicine Seattle, Washington	353,037
The Salvation Army New Brunswick, New Jersey <i>Program of assistance to the indigent (ID#6127)</i>	31,500
St. Peter's Medical Center New Brunswick, New Jersey <i>Purchase of equipment (ID#5422)</i>	125,000

	1980 grants authorized
St. Peter's Medical Center, School of Nursing New Brunswick, New Jersey <i>Nurse training program (ID#5341)</i>	\$ 30,000
St. Vincent de Paul Society Highland Park, New Jersey <i>Program of assistance to the indigent (ID#5506)</i>	17,000
University of South Dakota, School of Medicine Vermillion, South Dakota <i>Administration of the Foundation's Rural Infant Care Program (ID#5336)</i>	36,310
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The Foundation's Teaching Hospital General Medicine Group Practice Program <i>Improvement of ambulatory services for adult patients using medical clinics and emergency rooms as their regular source of care (ID#5554)</i>	
Albany Medical Center Hospital Albany, New York	799,594
University of California, Los Angeles, Center for Health Sciences Los Angeles, California	799,948
University of California, San Francisco, Hospitals and Clinics San Francisco, California	798,362
University of Colorado Health Sciences Center Denver, Colorado	769,443
Georgetown University, School of Medicine Washington, D.C.	735,409
The Johns Hopkins Hospital Baltimore, Maryland	768,402
The Mount Sinai Hospital New York, New York	799,330
New England Medical Center Hospital Boston, Massachusetts	799,922
College of Medicine and Dentistry of New Jersey Newark, New Jersey	800,000
North Carolina Memorial Hospital Chapel Hill, North Carolina	798,200
St. Louis University, School of Medicine St. Louis, Missouri	765,041
Vanderbilt University Nashville, Tennessee	798,158
Virginia Commonwealth University, Medical College of Virginia Richmond, Virginia	797,867

	1980 grants authorized
West Virginia University, School of Medicine Morgantown, West Virginia	\$ 783,578
Yale-New Haven Hospital New Haven, Connecticut	788,852
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United States Conference of Mayors Washington, D.C. <i>Dissemination of health services information (ID#4911)</i>	133,790
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United Student Aid Funds, Inc. New York, New York <i>The Foundation's Guaranteed Student Loan Program for medical, dental, and osteopathic students (ID#5553)</i>	1,500,000
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United Way of Central Jersey, Inc. Milltown, New Jersey <i>1980 campaign (ID#5418)</i>	195,000
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United Way—Princeton Area Communities Princeton, New Jersey <i>1980 campaign (ID#5508)</i>	30,000
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The Foundation's Urban Health Program <i>Planning and developing expanded ambulatory care services (ID#5331)</i>	
District of Columbia General Hospital Washington, D.C.	646,307
Hahnemann Medical College and Hospital of Philadelphia Philadelphia, Pennsylvania	649,057
Newark Beth Israel Medical Center Newark, New Jersey	681,999
The University of Texas, Southwestern Medical School at Dallas Dallas, Texas	625,924
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University of Utah, College of Medicine Salt Lake City, Utah <i>Development of a network of rural health programs (ID#5184)</i>	352,822
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Vanderbilt University, School of Nursing Nashville, Tennessee <i>Administration of the Foundation's Nurse Faculty Fellowships Program (ID#5337)</i>	135,613
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	1980 grants authorized
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Virginia Commonwealth University Richmond, Virginia	
<i>Administration of the Foundation's Hospital-Sponsored Ambulatory Dental Services Program (ID#5338)</i>	\$ 205,203
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University of Washington, School of Medicine Seattle, Washington	
<i>Analysis of the practice profiles of family and general practitioners (ID#5991)</i>	93,204
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	\$46,405,553
Refunds of prior years' grants	(390,412)
Cancellations of prior years' grants	(1,999,558)
Grants net for 1980	<u>\$44,015,583</u>

**Summary of grants
authorized in previous years,
and with unpaid balances on January 1, 1980**

Affiliated Hospitals Center, Inc.
Boston, Massachusetts

*Administration of the Foundation's Teaching
Hospital General Medicine Group Practice
Program (ID#5094)*

1979—\$215,840

University of Alabama, School of Nursing
Birmingham, Alabama

*Primary care training program for emergency
department nurses (ID#4077)*

1977—\$235,966

University of Alaska
Anchorage, Alaska

Rural health aide training program (ID#3790)

1978—\$164,694

Allegheny General Hospital
Pittsburgh, Pennsylvania

*Primary care training program for emergency
department nurses (ID#3036)*

1977—\$268,409

American College of Physicians
Philadelphia, Pennsylvania

*Support of the Society for Research and
Education in Primary Care Medicine
(ID#4260)*

1978—\$129,056

*Study of the practice and training of internists
(ID#5239)*

1979—\$158,550

American Fund for Dental Health
Chicago, Illinois

*Planning and implementation of a preventive
dental care program for school-age children
(ID#4770)*

1978—\$858,289; 1976—\$4,959,806

American Group Practice Foundation
Alexandria, Virginia

*Program to equip physicians with professional
management skills for group practices
(ID#2128)*

1976—\$499,825

American Health Planning Association
Washington, D.C.

*Development of area-wide planning for
ambulatory services (ID#5139)*

1979—\$260,000

Arizona State University, College of Nursing
Tempe, Arizona

*Rural emergency medical care training program
with Maricopa County Hospital (ID#0944)*

1976—\$294,540

University of Arizona, College of Medicine
Tucson, Arizona

*Special follow-up study of high risk neonates
(ID#4682)*

1978—\$563,594

Aspira of America, Inc.
New York, New York

*Program to increase minority enrollment in
medical schools (ID#5191)*

1979—\$365,203

Association of American Medical Colleges
Washington, D.C.

*Program to strengthen the management
capabilities of academic medical centers
(ID#3164)*

1977—\$539,732

*Financial aid administration programs
(ID#4657)*

1979—\$130,000

Association of Physician Assistant Programs
Arlington, Virginia

Support for the Association's national office
(ID#4506)

1979—\$225,000

Association of Science-Technology Centers
Washington, D.C.

Development of teaching materials in health
(ID#4302)

1978—\$176,915

Association of University Programs in Health
Administration
Washington, D.C.

*Summer internship program in health services
management (ID#3821)*

1978—\$299,962

Barrio Comprehensive Child Care Center
San Antonio, Texas

*Primary care service program for Mexican-
American children (ID#3834)*

1978—\$390,000

Bedford Stuyvesant Family Health Care
Center, Inc.

Brooklyn, New York

*Establishment of a primary care service
program in the inner city (ID#2787)*

1977—\$584,709

Boston City Hospital
Boston, Massachusetts

*Program to prepare physicians and nurses for
careers in general medical care (ID#2178)*

1975—\$1,189,677

*Development of urban health program for
adolescents and young families (ID#5036)*

1979—\$95,075

Program to train physicians in primary care
(ID#5011)

1979—\$100,000

Boston University
Boston, Massachusetts

*Developmental assistance for independent
practice associations (ID#4265)*

1978—\$441,425

Boys' Clubs of America
New York, New York

Health services and education program
(ID#0953)

1977—\$498,138

Brandeis University
Waltham, Massachusetts

*Support of the Committee on the Growth of
Hospital-Sponsored Ambulatory Care*
(ID#5180)

1979—\$608,881

Town of Brookline, Massachusetts, Public
Schools

Brookline, Massachusetts

*Health program for infants and preschool
children (ID#5181)*

1979—\$519,392; 1978—\$387,251

Cabin Creek Health Association
Cabin Creek, West Virginia

Community primary care health services
(ID#3039)

1977—\$176,551

University of California, Davis, School of
Medicine

Davis, California

*Program for the preparation and placement of
rural nurse practitioners (ID#2487)*

1976—\$455,323

University of California, Los Angeles
Los Angeles, California

*Planning and conducting an evaluation of the
Foundation's School Health Services
Program (ID#3133)*

1976—\$594,835

*Planning the evaluation of the Urban Health
Program (ID#5377)*

1979—\$24,971

University of California, Los Angeles, School of
Medicine

Los Angeles, California

Program to prepare physicians in primary care
(ID#2177)

1976—\$547,625

Study of health decision making among children
(ID#4126)
1977—\$303,461

University of California, San Francisco, School
of Medicine
San Francisco, California
Establishment of a health policy center
(ID#2455)
1976—\$1,000,000

*Program to prepare physicians and nurses in
primary care (ID#2030)*
1975—\$656,344

*Program to prepare faculty in emergency
medicine (ID#4819)*
1979—\$167,740; 1975—\$715,917

Case Western Reserve University, School of
Medicine
Cleveland, Ohio
Special follow-up of high risk neonates
(ID#4789)
1978—\$494,999

Center for Research in Ambulatory Health
Care Administration
Denver, Colorado
Financial management assistance program
(ID#3057)
1977—\$353,094

University of Chicago
Chicago, Illinois
*Evaluation of the Foundation's Community
Hospital-Medical Staff Group Practice
Program (ID#3869)*
1979—\$1,419,985; 1977—\$1,151,689

Children's Hospital Medical Center
Boston, Massachusetts
*Program to train clinical faculty in child
development (ID#4546)*
1979—\$497,340

*Administration of the Foundation's General
Pediatrics Academic Development Program*
(ID#4847)
1979—\$86,203

Chronic Disease Care Program
*Development of physician directed, nurse
managed programs providing ambulatory
care for patients with chronic diseases*
(ID#4555)

Cedars of Lebanon Hospital Corporation
Miami, Florida
1979—\$531,857

Daniel Freeman Hospital Medical Center
Inglewood, California
1979—\$553,045

Ellis Hospital
Schenectady, New York
1979—\$563,612

University of Oklahoma, Tulsa, Medical
College
Tulsa, Oklahoma
1979—\$535,074

La Clinica de la Raza
Oakland, California
*Program to improve community health
services (ID#3124)*
1977—\$267,185

Clinical Scholars Program
*National program to prepare young physicians
for new roles in medical care*
(ID#2493)

University of California, Los Angeles, School
of Medicine
Los Angeles, California
1977—\$714,232

University of California, San Francisco,
School of Medicine and Stanford
University, School of Medicine
San Francisco, California
1977—\$799,673

Columbia University, College of Physicians
and Surgeons
New York, New York
1977—\$187,745

- McGill University, McIntyre Medical
Sciences Center
Montreal, Quebec
1977—\$799,997
- University of North Carolina, School of
Medicine
Chapel Hill, North Carolina
1977—\$800,000
- University of Pennsylvania, School of
Medicine
Philadelphia, Pennsylvania
1977—\$799,478
- University of Washington, Seattle, School of
Medicine
Seattle, Washington
1977—\$600,147
- Yale University, School of Medicine
New Haven, Connecticut
1977—\$799,792
- Administrative Costs
Princeton, New Jersey
1979—\$65,000
- Columbia University
New York, New York
*Evaluation of the Foundation's Municipal
Health Services Program (ID#4027)*
1978—\$392,026
- Public policy programs in health services and
manpower (ID#5072)*
1979—\$423,967; 1976—\$333,773
- Tracking the distribution of ambulatory services
in major cities (ID#4535)*
1979—\$50,000
- Community Hospital-Medical Staff Group
Practice Program
*Grants for the development of hospital-
sponsored primary care group practices
(ID#4470)*
- Appalachian Regional Hospitals, Inc.
Lexington, Kentucky
1978—\$483,980
- Bethesda Lutheran Hospital
St. Paul, Minnesota
1976—\$499,790
- Crittenden Memorial Hospital
West Memphis, Arkansas
1976—\$494,029
- Durham County Hospital Corporation
Durham, North Carolina
1976—\$499,916
- Griffin Hospital
Derby, Connecticut
1976—\$500,000
- Hadley Memorial Hospital
Washington, D.C.
1976—\$457,006
- Hollywood Presbyterian Hospital—
Olmsted Memorial
Los Angeles, California
1976—\$499,981
- Holston Valley Community Hospital
Kingsport, Tennessee
1976—\$466,197
- Holy Cross Hospital
Salt Lake City, Utah
1979—\$56,692
- Humboldt General Hospital
Winnemucca, Nevada
1977—\$500,000
- Huron Road Hospital
East Cleveland, Ohio
1979—\$500,000
- Jackson Hospital and Clinic, Inc.
Montgomery, Alabama
1979—\$492,214
- Joint Hospital Committee for Extramural
Affairs
Aberdeen, Washington
1977—\$494,160
- La Crosse Lutheran Hospital
La Crosse, Wisconsin
1977—\$244,547

Lakewood Hospital
Lakewood, Ohio
1976—\$498,020

Lutheran Charities Association of St. Louis,
Missouri
St. Louis, Missouri
1976—\$475,105

Lutheran General and Deaconess Hospitals
Park Ridge, Illinois
1976—\$500,000

Lutheran Hospital and Medical Center
Wheat Ridge, Colorado
1976—\$500,000

Lutheran Hospital of Maryland, Inc.
Baltimore, Maryland
1976—\$496,170

Marion County Hospital Authority
Buena Vista, Georgia
1978—\$500,000

The Memorial Hospital
Worcester, Massachusetts
1976—\$475,000

Memorial Hospital of Alamance County, Inc.
Burlington, North Carolina
1976—\$487,944

Memorial Hospital of Phoenix
Phoenix, Arizona
1976—\$498,942

Mercy Hospital
Springfield, Massachusetts
1976—\$490,000

Mercy Hospital
Watertown, New York
1977—\$500,000

Mercy Hospital, Inc.
Baltimore, Maryland
1976—\$499,985

Nashua Hospital Association
Nashua, New Hampshire
1977—\$500,000

New York Infirmery
New York, New York
1977—\$500,000

Northeast Alabama Regional Medical Center
Anniston, Alabama
1979—\$500,000

Providence Hospital
Washington, D.C.
1978—\$500,000

Providence Medical Center
Seattle, Washington
1977—\$500,000

Richmond Memorial Hospital
Richmond, Virginia
1976—\$497,000

St. Aloisius Hospital
Harvey, North Dakota
1976—\$499,533

St. Francis Hospital
Honolulu, Hawaii
1976—\$491,030

St. Francis Hospital
Topeka, Kansas
1976—\$446,296

St. Joseph Hospital
Lancaster, Pennsylvania
1976—\$497,620

St. Joseph Mercy Hospital
Ann Arbor, Michigan
1978—\$499,910

St. Joseph's Hospital and Medical Center
Paterson, New Jersey
1976—\$500,000

St. Lawrence Hospital
Lansing, Michigan
1977—\$491,993

St. Luke's Hospital
Aberdeen, South Dakota
1976—\$498,169

- St. Vincent Hospital and Medical Center
Portland, Oregon
1977—\$499,727
- St. Vincent's Hospital
Billings, Montana
1976—\$499,709
- San Bernardino County Medical Center
San Bernardino, California
1977—\$499,967
- Scottsdale Memorial Hospital
Scottsdale, Arizona
1977—\$498,103
- Sisters of Mercy Health Corporation
Sioux City, Iowa
1977—\$500,000
- Herbert J. Thomas Memorial Hospital
Association
South Charleston, West Virginia
1976—\$485,456
- Waterville Osteopathic Hospital
Waterville, Maine
1977—\$467,994
- Wausau Hospital, Inc.
Wausau, Wisconsin
1977—\$456,117
- Williamsburg County Memorial Hospital
Kingstree, South Carolina
1977—\$485,185
- Charles S. Wilson Memorial Hospital
Johnson City, New York
1976—\$469,361
- Comprehensive Interdisciplinary
Developmental Services, Inc.
Elmira, New York
*Study of Chemung County, New York,
maternal and early infant care program
(ID#5263)*
1979—\$183,203
- University of Connecticut Health Center
Hartford, Connecticut
*Development of a school-based health care
program (ID#3835)*
1978—\$537,225
- Cooper Medical Center
Camden, New Jersey
*Development of an integrated urban health
system for Camden City (ID#5089)*
1979—\$374,527
- Cornell University, Medical College
New York, New York
*Study of doctor-patient communications
(ID#2473)*
1976—\$243,091
*Administration of the Foundation's Chronic
Disease Care Program (ID#5030)*
1979—\$147,333
- The East Los Angeles Community Union
East Los Angeles, California
*Support of a family health care center
(ID#5158)*
1979—\$232,000
- Educational Testing Service
Princeton, New Jersey
*Evaluation of the Foundation's program to
train dentists in the care of the handicapped
(ID#4890)*
1979—\$81,029
- Family Practice Faculty Fellowship Program
*Program to prepare physicians for academic
careers in family practice (ID#3457)*
- Case Western Reserve University, School of
Medicine
Cleveland, Ohio
1978—\$538,503
- University of Iowa, College of Medicine
Iowa City, Iowa
1977—\$781,051
- University of Missouri, Columbia, School of
Medicine
Columbia, Missouri
1978—\$654,944
- University of Utah, College of Medicine
Salt Lake City, Utah
1977—\$587,601

- University of Washington, Seattle, School of
Medicine
Seattle, Washington
1977—\$623,832
- University of Florida, College of Medicine
Gainesville, Florida
*Program to train physicians in primary care
(ID#4808)*
1978—\$449,794
- Foundation for Comprehensive Health Services
Sacramento, California
*Primary care delivery for rural California
(ID#3789)*
1977—\$475,000
- General Pediatrics Academic Development
Program
*Grants to expand research and training for
academic careers in general pediatrics
(ID#4610)*
- Duke University Medical Center
Durham, North Carolina
1979—\$723,123
- The Johns Hopkins University, School of
Medicine
Baltimore, Maryland
1979—\$800,000
- Medical Associates Research and Education
Foundation
Philadelphia, Pennsylvania
1979—\$799,968
- University of Rochester, School of Medicine
and Dentistry
Rochester, New York
1979—\$837,570
- Stanford University, School of Medicine
Stanford, California
1979—\$842,604
- Yale University, School of Medicine
New Haven, Connecticut
1979—\$787,165
- The George Washington University
Washington, D.C.
*Seminar program for government health staff
professionals (ID#3117)*
1977—\$575,000
- National Health Policy Forum (ID#5209)*
1979—\$300,000
- Georgetown University, School of Medicine
Washington, D.C.
Analysis of health policy issues (ID#4195)
1979—\$187,495
- Developing a system of medically assisted self
care (ID#4485)*
1979—\$431,888
- Georgia Department of Human Resources
Atlanta, Georgia
*Primary care health services program
(ID#3830)*
1979—\$615,781
- Good Samaritan Hospital and Medical Center
Portland, Oregon
*Primary care training for emergency nurses
(ID#4512)*
1978—\$314,459
- Group Health Foundation
Washington, D.C.
*Program to equip physicians with professional
management skills (ID#4985)*
1979—\$151,280
- Harvard University, Medical School
Boston, Massachusetts
*Program to train physicians for primary medical
care (ID#3089)*
1977—\$733,788
- Harvard University, School of Public Health
Cambridge, Massachusetts
*Support of the School of Public Health
(ID#5213)*
1979—\$670,000; 1976—\$1,000,000
- Health Care Institute, Inc.
Detroit, Michigan
*Development of a primary care service and
education program (ID#2042)*
1977—\$176,820

- Hermann Hospital Estate
Houston, Texas
*Primary care training for emergency nurses
(ID#4078)*
1978—\$322,211
- Hospital-Sponsored Ambulatory Dental
Services Program
*Programs of general and emergency dental care
and oral hygiene education for dentally-
underserved people (ID#4553)*
- Affiliated Hospitals Center, Inc.
Boston, Massachusetts
1979—\$340,165
- Buffalo General Hospital
Buffalo, New York
1979—\$500,000
- The Genesee Hospital
Rochester, New York
1979—\$337,033
- Highland General Hospital
Oakland, California
1979—\$321,503
- Illinois Masonic Medical Center
Chicago, Illinois
1979—\$414,275
- University of Iowa Hospitals and Clinics
Iowa City, Iowa
1979—\$497,443
- Loma Linda University Medical Center
Loma Linda, California
1979—\$383,838
- Long Island Jewish-Hillside Medical Center
New Hyde Park, New York
1979—\$399,518
- Lutheran Medical Center
Brooklyn, New York
1979—\$499,925
- Middlesex General Hospital
New Brunswick, New Jersey
1979—\$449,366
- Newark Beth Israel Medical Center
Newark, New Jersey
1979—\$498,366
- North Carolina Memorial Hospital
Chapel Hill, North Carolina
1979—\$500,000
- The Medical College of Pennsylvania
Philadelphia, Pennsylvania
1979—\$444,097
- Provident Hospital, Inc.
Baltimore, Maryland
1979—\$343,385
- Public Health Trust of Dade County,
Florida—Jackson Memorial Hospital
Miami, Florida
1979—\$435,390
- The Richmond County Hospital Authority
Augusta, Georgia
1979—\$326,966
- St. Anthony Hospital
Oklahoma City, Oklahoma
1979—\$210,856
- St. Clare's Hospital
Schenectady, New York
1979—\$401,581
- St. Francis Hospital
Honolulu, Hawaii
1979—\$471,387
- St. Francis Hospital and Medical Center
Hartford, Connecticut
1979—\$291,794
- St. Luke's Hospital
Cleveland, Ohio
1979—\$336,388
- University of Southern California Medical
Center
Los Angeles, California
1979—\$444,963
- University of Tennessee Memorial Hospital
and Research Center
Knoxville, Tennessee
1979—\$411,796

- University of Washington, School of
Dentistry
Seattle, Washington
1979—\$464,567
- Wilmington Medical Center
Wilmington, Delaware
1979—\$409,360
- Hyde Park-Kenwood Community Health
Center, Inc.
Chicago, Illinois
*Development of a primary care health services
program (ID#3269)*
1977—\$238,825
- Indiana University Foundation
Indianapolis, Indiana
*Program to prepare clinical nursing faculty in
primary care (ID#3844)*
1978—\$240,029
- Institute for Prepayment Studies, Inc.
Newark, New Jersey
*Evaluation of a primary care oriented
reimbursement system (ID#4352)*
1979—\$498,923
- University of Iowa, College of Medicine
Iowa City, Iowa
*Advanced emergency medicine for physician
assistants and emergency nurses (ID#4837)*
1979—\$309,419
- Jackson State University
Jackson, Mississippi
*Program to increase minority enrollment in
medical schools (ID#5342)*
1979—\$104,780
- The Johns Hopkins Hospital
Baltimore, Maryland
*Administration of the Foundation's Municipal
Health Services Program (ID#4410)*
1979—\$118,971
- Foster family care program for the frail elderly
(ID#4617)*
1978—\$164,197
- The Johns Hopkins University, Center for
Health Services Research and Development
Baltimore, Maryland
*Evaluation of the Foundation's Perinatal
Program (ID#4023)*
1978—\$795,000
- The Johns Hopkins University, School of
Medicine
Baltimore, Maryland
*Program to prepare faculty in emergency
medicine (ID#3206)*
1978—\$713,554
- Joint Commission on Accreditation of Hospitals
Chicago, Illinois
*Ambulatory health care services accreditation
program (ID#2428)*
1976—\$338,165
- Lake Erie College
Painesville, Ohio
*Program with the Cleveland Clinic to train
physician assistants (ID#5013)*
1979—\$182,242
- Maine Medical Center
Portland, Maine
*Postgraduate physician assistant residency
program in emergency medicine (ID#4844)*
1979—\$295,171
- Maricopa County General Hospital Research
Foundation
Phoenix, Arizona
*Primary care training for emergency nurses
(ID#3786)*
1978—\$291,314
- Mayo Foundation
Rochester, Minnesota
*Development of a primary care satellite
network (ID#3809)*
1977—\$350,000
- Meharry Medical College
Nashville, Tennessee
Faculty development program (ID#3216)
1977—\$2,500,000

- University of Michigan, School of Public Health
Ann Arbor, Michigan
Program on health manpower development (ID#2479)
1976—\$424,911
- University of Mississippi Medical Center
Jackson, Mississippi
Program to increase minority enrollment in medical schools (ID#4632)
1979—\$368,717
- Montefiore Hospital and Medical Center
Bronx, New York
Development and implementation of a service program for adolescents with chronic illness (ID#4858)
1979—\$338,744
- Administration of the Foundation's Urban Health Program (ID#5029)*
1979—\$173,988
- Morehouse College
Atlanta, Georgia
Program to increase minority enrollment in medical schools (ID#4977)
1979—\$384,995; 1976—\$471,225
- Mount Sinai School of Medicine
New York, New York
Administrative grant for senior program consultant services (ID#3840)
1978—\$138,973
- Administration of the Foundation's Program for the Health-Impaired Elderly and Perinatal Program (ID#3870)*
1979—\$155,179
- Municipal Health Services Program
Program to expand municipally-sponsored inner-city health services (ID#3960)
- City of Baltimore, Maryland
1978—\$2,852,275
- City of Cincinnati, Ohio
1978—\$3,000,000
- City of Milwaukee, Wisconsin
1978—\$2,963,570
- City of St. Louis, Missouri
1978—\$3,000,000
- City of San Jose, California
1978—\$2,975,205
- National Academy of Sciences, Institute of Medicine
Washington, D.C.
Administration of The Robert Wood Johnson Health Policy Fellowships Program (ID#4496)
1978—\$408,430
- Support of the Institute of Medicine (ID#3836)*
1978—\$750,000
- National Academy of Sciences, National Research Council
Washington, D.C.
Support of the Academy's Emergency Medical Service Committee (ID#2162)
1975—\$274,200
- National Board of Medical Examiners
Philadelphia, Pennsylvania
Program to complete the development of a computer-based license examination (ID#2576)
1977—\$475,000
- National Bureau of Economic Research
New York, New York
Research and training program in health economics (ID#3081)
1976—\$274,091
- The National Council on the Aging, Inc.
Washington, D.C.
Expand health care services for the elderly (ID#4696)
1978—\$350,000
- National Foundation for Dentistry for the Handicapped
Denver, Colorado
Program to increase dental services for the handicapped (ID#5064)
1979—\$272,402

National Fund for Medical Education
Hartford, Connecticut
*Support of summer programs for minority
premedical students (ID#4474)*
1978—\$175,000

National 4-H Council
Chevy Chase, Maryland
*Health education program development
(ID#2754)*
1977—\$201,308

National League for Nursing
New York, New York
*Summer study program in health policy
(ID#3121)*
1977—\$145,684

*Study of employment patterns for recently
graduated nurses (ID#4949)*
1979—\$50,000

Nebraska Methodist Hospital
Omaha, Nebraska
*Primary care training for emergency nurses
(ID#4689)*
1978—\$306,113

University of Nevada, School of Medical
Sciences
Reno, Nevada
*Enhancement of rural health care in the state
(ID#4703)*
1979—\$400,073

New Brunswick Tomorrow
New Brunswick, New Jersey
*City of New Brunswick redevelopment program
(ID#3614)*
1977—\$1,500,000

College of Medicine and Dentistry of
New Jersey
Newark, New Jersey
*Program to prepare minority students for
preprofessional careers in medicine and
dentistry (ID#2795)*
1976—\$264,592

College of Medicine and Dentistry of
New Jersey, Rutgers Medical School
Piscataway, New Jersey
*Program to strengthen family physician training
in New Jersey (ID#2636)*
1976—\$450,340

University of North Carolina
Chapel Hill, North Carolina
*Administration of the Foundation's Rural
Practice Project (ID#2115)*
1975—\$2,074,081

Study of rural health care initiatives (ID#4080)
1978—\$476,927

University of North Carolina, School of Public
Health
Chapel Hill, North Carolina
*Role of state and local health departments in
ambulatory care (ID#4344)*
1978—\$121,732

Northwestern University
Evanston, Illinois
*Research on the management of ambulatory
care services (ID#4429)*
1978—\$225,000

Nurse Faculty Fellowships Program
*Program to equip nursing faculty with primary
clinical skills (ID#4694)*

University of Colorado Medical Center,
School of Nursing
Denver, Colorado
1979—\$534,320; 1975—\$675,000

Indiana University Foundation
Indianapolis, Indiana
1979—\$537,254; 1975—\$675,000

University of Maryland, School of Nursing
Baltimore, Maryland
1979—\$536,646; 1975—\$675,000

University of Rochester, School of Nursing
Rochester, New York
1979—\$505,930; 1975—\$665,054

- University of Oklahoma, College of Medicine
Oklahoma City, Oklahoma
Development of a pediatric primary care program (ID#4325)
1979—\$399,146
- University of Oregon Health Sciences Center,
School of Nursing
Portland, Oregon
Data collection and analysis of the Foundation's Nurse Faculty Fellowships Program (ID#3682)
1979—\$201,667; 1976—\$123,947
- Pace University, Graduate School of Nursing
New York, New York
Graduate program in primary care nursing (ID#3839)
1978—\$350,030
- Pennsylvania State Department of Health
Harrisburg, Pennsylvania
A statewide program to improve school health services (ID#4744)
1979—\$404,360
- The Pennsylvania State University, College of Human Development
University Park, Pennsylvania
Support of a program to assist seven rural group practices (ID#4472)
1979—\$343,107
- University of Pennsylvania
Philadelphia, Pennsylvania
Study of chronic care in association with Middlesex General Hospital, New Brunswick, New Jersey (ID#5212)
1979—\$123,589
- University of Pennsylvania, School of Dental Medicine
Philadelphia, Pennsylvania
Dental care program for school-age children in rural Pennsylvania (ID#3837)
1977—\$547,000
- University of Pennsylvania, School of Medicine
Philadelphia, Pennsylvania
Program to train physicians for careers in primary care (ID#1499)
1977—\$401,765
- University of Pennsylvania, School of Nursing
Philadelphia, Pennsylvania
Graduate program in primary care nursing (ID#4271)
1978—\$543,943
- University of Pittsburgh, Graduate School of Public Health
Pittsburgh, Pennsylvania
Development of a guide for financing, organizing, and staffing pre-hospital emergency medical service (ID#5140)
1979—\$171,569
- Posen-Robbins School District
Posen, Illinois
Planning and development of a school-based health care system (ID#3305)
1977—\$467,527
- The Rand Corporation
Santa Monica, California
Planning and conducting the evaluation of a preventive dental care program for school-age children (ID#4769)
1978—\$1,563,219
- Rio Grande Federation of Health Centers, Inc.
San Antonio, Texas
Support of a technical assistance program (ID#4826)
1979—\$332,108
- University of Rochester, School of Medicine and Dentistry
Rochester, New York
Program to train physicians for careers in primary care (ID#3090)
1977—\$643,760
- Administration of the Foundation's Community Hospital-Medical Staff Group Practice Program (ID#3755)*
1979—\$406,242; 1978—\$448,948
- University of Rochester, School of Nursing
Rochester, New York
Graduate program in primary nursing (ID#4350)
1978—\$424,560

Roxbury Dental and Medical Group
Roxbury, Massachusetts
Support of an urban group practice (ID#3649)
1977—\$106,000

Rural Practice Project
Program to develop nonprofit group medical practices in rural areas (ID#2382)

Bakersville Community Medical Clinic, Inc.
Bakersville, North Carolina
1975—\$288,269

Dunes Family Health Care, Inc.
Reedsport, Oregon
1975—\$460,457

Family Health Care, Inc.
Tooele, Utah
1975—\$443,897

Mille Lacs Family Health Foundation, Inc.
Onamia, Minnesota
1975—\$483,970

Mission Valley Health Services Center, Inc.
St. Ignatius, Montana
1975—\$471,616

New River Health Association, Inc.
Scarbro, West Virginia
1975—\$412,331

Palmetto Family Health Care Center, Inc.
Pacolet, South Carolina
1975—\$98,000

Peninsula Family Practice, Inc.
Leland, Michigan
1975—\$463,062

Roanoke-Amaranth Community Health Group, Inc.
Jackson, North Carolina
1975—\$499,500

Surry County Family Health Group, Inc.
Surry, Virginia
1975—\$499,406

Rutgers University
New Brunswick, New Jersey
Studies in the organization of health care services (ID#5074)
1979—\$185,576

St. Vincent de Paul Society
New Brunswick, New Jersey
Program of assistance to the indigent (ID#3876)
1979—\$17,000

Salvation Army
New Brunswick, New Jersey
Program of assistance to the indigent (ID#3875)
1979—\$27,000

School Health Services Program
Program to improve school-based child health services (ID#3239)

Colorado Department of Health
Denver, Colorado
1978—\$1,177,256

New York State Education Department
Albany, New York
1978—\$1,200,000

North Dakota State Department of Health
Bismarck, North Dakota
1978—\$1,200,000

Utah State Board of Education
Salt Lake City, Utah
1978—\$1,200,000

Scranton Primary Health Care Center, Inc.
Scranton, Pennsylvania
Development of a primary care group practice (ID#4171)
1978—\$457,931

Seton Hall University, College of Nursing
South Orange, New Jersey
Program in clinical primary care nursing (ID#3701)
1978—\$455,685

- University of South Dakota, School of Medicine
Vermillion, South Dakota
*Administration of the Foundation's Rural
Infant Care Program (ID#5147)*
1979—\$177,089
- University of Southern California, School of
Medicine
Los Angeles, California
*Study of the role of medical specialists in
primary care (ID#2050)*
1975—\$1,403,644
- A college-medical school consortium for
disadvantaged premedical students
(ID#4219)*
1978—\$637,936
- Study of practice profiles of graduates of
primary care residency programs (ID#4690)*
1979—\$364,243
- Stanford University Medical Center
Stanford, California
*Support of a research and training program in
ambulatory pediatrics (ID#3229)*
1977—\$272,498
- Study of the training of new health practitioners
in primary care, with the University of
California, Davis (ID#2944)*
1976—\$198,573
- Tennessee Department of Public Health
Nashville, Tennessee
*Development of a primary care center in
Hamilton County (ID#2209)*
1975—\$417,346
- University of Tennessee, College of Medicine
Memphis, Tennessee
*Development of a regional primary care
network (ID#3208)*
1978—\$480,000
- University of Texas Medical Branch at
Galveston
Galveston, Texas
*Primary care services for school-age children
(ID#2763)*
1976—\$1,171,960
- Tufts University, School of Medicine
Boston, Massachusetts
*Analysis of policy issues impacting on the future
of medical care (ID#4851)*
1979—\$179,998
- Tulane Medical Center
New Orleans, Louisiana
*Program to increase minority enrollment in
medical schools (ID#4478)*
1978—\$300,000
- Tuskegee Institute
Tuskegee Institute, Alabama
*Development of a primary care health service
program in rural Alabama (ID#3850)*
1979—\$347,722; 1975—\$1,266,438
- United States Conference of Mayors
Washington, D.C.
*Analysis of the financial needs of service
programs in inner-city areas (ID#3994)*
1977—\$234,951
- United Way of Minneapolis Area
Minneapolis, Minnesota
*Planning effort for coordinated health services
to seniors (ID#4516)*
1978—\$64,000
- United Way-Princeton Area Communities
Princeton, New Jersey
Annual contribution (ID#3874)
1979—\$30,000
- Urban Health Program
*Grants to plan and develop expanded
ambulatory care services (ID#4866)*
- Bexar County Hospital District
San Antonio, Texas
1979—\$600,000
- Case Western Reserve University, School of
Medicine
Cleveland, Ohio
1979—\$609,079
- Charles R. Drew Postgraduate Medical
School
Los Angeles, California
1978—\$600,000

- Louisiana State University, New Orleans
New Orleans, Louisiana
1978—\$633,662
- Montefiore Hospital and Medical Center
Bronx, New York
1978—\$608,365
- Sisters of Mercy Health Corporation
Farmington Hills, Michigan
1978—\$640,650
- University of Southern California, School of
Medicine
Los Angeles, California
1979—\$596,130
- University of Utah, College of Medicine
Salt Lake City, Utah
*Development of a network of rural health
programs (ID#4702)*
1979—\$177,778
- Vanderbilt University, Center for Health
Services
Nashville, Tennessee
*Program to improve rural community health
services (ID#3838)*
1978—\$404,630
- Vanderbilt University, School of Medicine
Nashville, Tennessee
Planning for a primary care center (ID#3673)
1978—\$249,979
- Vanderbilt University, School of Nursing
Nashville, Tennessee
*Administration of the Foundation's Nurse
Faculty Fellowships Program (ID#4910)*
1979—\$149,748
- Virginia Commonwealth University
Richmond, Virginia
*Administration of the Foundation's Hospital-
Sponsored Ambulatory Dental Services
Program (ID#4733)*
1979—\$227,772; 1978—\$237,544
- University of Washington, Seattle
Seattle, Washington
*Evaluation of the Foundation's Community
Hospital-Medical Staff Group Practice
Program (ID#4189)*
1979—\$387,639; 1977—\$287,438
- University of Washington, Seattle, School of
Medicine
Seattle, Washington
*Program to train physicians for careers in
primary care (ID#4272)*
1977—\$554,636
- University of Washington, Seattle, School of
Nursing
Seattle, Washington
*Graduate program in primary care nursing
(ID#3802)*
1978—\$649,413

Secretary's report

Secretary's Report

Staff Changes*

Two members of the senior staff left the Foundation in 1980. Margaret E. Mahoney, who joined us as vice president in 1972, resigned in July to become president of the Commonwealth Fund in New York City. Miss Mahoney, who joined the Foundation from the Carnegie Corporation, had major responsibility for organizing our professional staff and developing our grants program in our first years as a national philanthropy. She was particularly active in our efforts with children's health services and to increase opportunities for minorities and women in medical education.

In October, Thomas W. Moloney, assistant vice president, left to join Miss Mahoney at the Commonwealth Fund as senior vice president. Mr. Moloney came to the Foundation in October 1975 and made important contributions to our program development and planning, particularly in our work with teaching hospitals and in analyzing trends in health care financing.

Also in 1980, three program officers—Frank Jones, Marc Voyvodich, and Thomas E. Gregg—left the Foundation. Mr. Jones, one of the first members of our program staff, was involved in our work in dentistry and child care programs. In February he accepted a position as executive director of the Associated Medical Schools of New York in New York City.

Mr. Voyvodich, who joined the Foundation in 1978, helped to develop our grant programs in rural health care and emergency medical services. In May, he accepted a position as executive director of the South Maine Association of Cooperating Hospitals in Bramhall, Maine.

Mr. Gregg, a member of the staff since July 1979, left in January 1981 to become a consultant in the health and medical division of Booz, Allen and Hamilton in New York City. At the Foundation, Mr. Gregg had assisted in the planning and development of some of our new program areas.

Three individuals joined the professional staff this year. In September, F. Catherine McCaslin, Ph.D., joined the program staff from the Kaiser Foundation Health Plan in Los Angeles, where she was senior survey analyst. Dr. McCaslin is a graduate of Hollins College, has a master's degree in sociology from Georgia State University, and received her

*To present as up-to-date a picture of staff changes as possible, this report covers the period through February 16, 1981.

doctorate in medical sociology from the University of California, Los Angeles.

Douglas H. Morgan joined the Foundation as a program officer in December. Mr. Morgan, who had served in various posts in the Newark, New Jersey municipal government since 1971, left his position as director of the Department of Health and Welfare to join the Foundation. He is a graduate of Rutgers University and received his master's degree in public administration, health planning and policy analysis from New York University.

In July, Philip J. Driscoll joined the Foundation as financial analyst. Mr. Driscoll previously worked for Leberthal and Company, Inc., in New York City. He is a Vassar College graduate, and holds a master's degree in business administration—finance from Columbia University Graduate School of Business.

Three members of the professional staff were elected to new positions in 1980. Robert J. Blendon, Sc.D., who joined the staff in 1972 as vice president, was elected senior vice president. Ruby Hearn, Ph.D., who joined the staff in 1975, was elected assistant vice president. William E. Walch, who also joined the staff in 1975, was elected assistant vice president for communications.

Board activities

The Board of Trustees met six times in 1980 to conduct business, review proposals, and appropriate funds. The Board devoted considerable time to the development of the Foundation's new program guidelines. In addition, the Policy, Finance, and Audit Committees met as required to consider and prepare recommendations to the Board.

J. Warren Wood, III
Secretary and General Counsel

Application for grants

The Robert Wood Johnson Foundation is a private philanthropy interested in improving health in the United States. We are concentrating our resources on a few well defined needs in health: the need to improve access to personal health care for the most underserved population groups; the need to make health care arrangements more effective and care more affordable; and the need to help people maintain or regain maximum attainable function in their everyday lives.

To increase the potential impact of our grant funds within our three areas of interest, we have further defined our role to assist:

- development and testing of new and previously untried approaches to health care problems;
- demonstrations to objectively assess the operational effectiveness and value of selected new health care arrangements and approaches which have been shown to be effective in more limited settings; and
- projects designed to promote the broader diffusion of programs that have been objectively shown to improve health status or to make health care more affordable.

We give priority to proposed programs and projects that address regional or national problems. The one exception to this and our other guidelines is support for a small number of activities in New Brunswick, New Jersey where the Foundation originated.

Policy guidelines established by our board of trustees will normally preclude support for the following types of activities: (1) on-going general operating expenses; (2) endowment, construction, or equipment; (3) basic biomedical research; (4) international activities or programs and institutions in other countries; and (5) direct support to individuals.

Also, we do not support programs concerned solely with a specific disease or with broad public health problems, except as they might relate to our three areas of interest. The decision not to support such programs, worthy though they are, in no way implies a failure to recognize their importance. It is simply a consequence of the conviction that progress in the areas we have selected depends in large measure on our ability to concentrate our funds. Unfortunately, even within our program interests and guidelines, requests have always exceeded our resources, and thus we are unable to support many deserving proposals.

There are no formal grant application forms. Applicants should

prepare a letter which states briefly and concisely the proposed project as well as its objectives and significance; the qualifications of the organization and the individuals concerned; the mechanisms for evaluating results; and a budget. This letter should be accompanied by a copy of the applicant institution's tax exempt status under the Internal Revenue Code. Ordinarily, preference will be given to organizations which have qualified for exemption under Section 501(c)(3) of the Internal Revenue Code, and which are not "private foundations" as defined under Section 509(a). Public instrumentalities performing similar functions are also eligible.

Proposal letters should be addressed to:

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